This message is a summary of just one of the complicated issues that are will have to be faced not only by the systems folks, but more importantly by those who will use those systems. I believe that it is going to be much harder for the paramedic in the field than it will be for the data systems. I have also attached a one page document that gives some definitions of the terms used. The definitions were taken from the original rule that was proposed.

 <<ICD9-HCPCS-NCD-Defs.rtf>>

-----Original Message-----
From: kepa.zubeldia@envoy.com [mailto:kepa.zubeldia@envoy.com]
Sent: Friday, September 22, 2000 7:40 AM
To: wes.rishel@gartner.com; x12n@disa.org; MStoogenke@hcfa.gov ;
AFEHCT@aol.com; Schups@aol.com; MEmerson@hcfa.gov ; KTrudel@hcfa.gov
Subject: Re:RE: J-codes issue

Wes,

This is an excellent summary. One more challenge I would add is the problem faced by payers that are now using the J codes for adjudication. When they map the NDC code to a J code for adjudication, they need to report back to the submitter an 835 using the NDC code submitted, thus the need for a reverse mapping from the J code to something that is either the submitted NDC code or a replacement for it.
I agree with you that there is not a perfect solution that we could all adopt. Thus the need for an industry consensus. It does not matter much what the consensus will be, as long as we all agree to it.
As for the duration of the pseudo codes, if adopted, I think they should sunset one year after the mandated compliance data of HIPAA at the latest. These should only be used for a transition period, and never as a permanent solution.
Jan Root pointed out to me that when coding mechanisms change (remember the CPT changes to E&M codes about 8 years ago ?) then HCFA issues instructions to the carriers and intermediaries on how to cope with the change, what replacement codes to use, or, if there is not a 1:1 mapping (and there was not a 1:1 mapping with the E&M codes) how to handle the transition in general. Essentially, all we need for the J codes vs. NDC codes problem is to have an industry consensus to adopt the same instructions that HCFA prepares, and maybe to work with HCFA in preparing those instructions. Then we will have a de-facto consensus, as everybody else follows what HCFA does.
Kepa Zubeldia
ENVOY Corporation

_____Reply Separator_____
Subject: RE: J-codes issue
Author: "Rishel Wes" <wes.rishel@gartner.com>
Date: 9/22/00 2:00 AM

Jan and Kepa, I am sorry to come late to this party, but I have reviewed what I believe to be the entire thread, and I am still fair to middlin' confused.
Let me review the bidding here and perhaps someone can show me what I have missed.
1)   The final rule requires NDC codes for drugs and biotics.
2)   There is a complex, non-reversible mapping between J-codes and units of service on the one hand, and NDC codes and units of service on the other. Specifically it is possible, but not as simple as a table lookup, to map from NDC to J, but when going in the other direction one combination of J and units of service could map to many, many different NDC codes, with appropriate units of service.
3)   There are various challenges (he says diplomatically) in converting from J to NDC
a)   NDC is a far more volatile code set: weekly updates
b)   The NDC code for a common therapy, say an injection of ampicillin, varies according to details such as the packaging and manufacturer, but to capture this information correctly adds labor to provider processes that are already stretched thin ... administrative desimplification for the provider.
c)   NDC is larger code ... 11 characters versus 5; for systems that are built in COBOL or not using a DBMS that deals with variable-length strings

this represents substantial code remediation. For more modern systems there is still analysis and remediation to deal with screen and report formats.
d)	NDC is a larger code set ... 528 J codes versus approximately 100K NDC codes ... (could I possibly be right about the number of J codes? I determined it by downloading anweb.xls from the URL that Kepa provided, and counting the J rows.) But disk storage is cheap, right? OTOH, the user interface issues associated with picking an item from a list of 528 are different than from a list of 100K. The remediation will be more than just plugging in a different code set.
e)	In addition to the programming costs above, users of adjudication systems face a burden of mapping their current tables that determine what is paid or denied to NDC codes.
Arguably, this task is not as daunting as it sounds, at least
to generate the same adjudication decisions that now occur. It requires
the one-way mapping from NDC to J codes, but that can easily be constructed by one of the vendors that adds value to NDC codes, if it has not already been done.
f)	What challenges have I left out?

4)	The HIPAA law requires certain support from DHHS that apparently has not been forthcoming. Kepa cited section 1174(b)(2)(B)(ii) of the law, which says:

"Additional rules.- If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification."
5)	The group voted overwhelmingly to have DHHS produce a 1:1 crosswalk, but this is a bit like me saying I would have fewer orthopedic problems if DHHS would reduce the force of gravity to about 0.8g. There is no 1:1 crosswalk. Various proposals that might be thought of as a 1:1 crosswalk are:

a)	DHHS could become a labeler and issue a set of "J codes in NDC clothing", permitted for some interim period, that would effectively delay the implementation of NDC codes until the interim period was over.

There was some discussion of having a transition wherein payers could specify whether they would process the real NDC code or the pseudo NDC code, but this strongly violates the spirit of HIPAA: providers would once again have to have payer-specific logic in their systems. It also gives comfort to the payers, but not the providers who must fully implement NDC from the get-go in order to deal with payers that want it.
If there is to be such a transition, better that it be until   a date certain, when NDC codes really become used.
At first blush, this seems to remove the need for remediation, because translations to/from pseudo NDC codes could be handled by translators. On the other hand, in a sidebar Kepa described complex instructions for using J codes and Type of Service that are inconsistent among Federal reimbursement programs. If the Transaction standard has made these uniform, then there is still going to be remediation required, so one must ask what is the incremental cost of going to NDC?
Furthermore, we saw descriptions where payers frequently require NDC now, precisely because it provides more information than J codes. Going to pseudo NDC codes uniformly would deny them that information and require their systems to be remediated.
b)	There was a proposal to create "NDC codes in J clothing" by taking the second group of digits of the NDC code, which identify the product but not the packaging, and prepending a "J". This would work if different labelers used the same four digits for the same product, but this is not the case, so it won't work.
c)	I don't believe there was another proposal, was there?

Qualitatively, we have seen two kinds of challenges:
o the need for code remediation in payer and provider systems
o the need for ongoing additional manual work in provider

systems to capture the NDC code

Of these, the latter seems to have more long term consequences.
So, what have I missed?
In any case, here is my confusion: is there yet a workable proposal that
meets the needs of payers and providers for a "pseudo-1:1 crosswalk?" If so,
I think I must have missed it.
> -----Original Message-----
> From: Jan Root [mailto:janroot@uhin.com]
> Sent: Wednesday, September 13, 2000 7:06 AM
> To: x12n@disa.org
> Subject:J-codes issue
>
>
>
> Well, although Bob certainly makes a good case, the overwhelming
> majority of the people that responded to the question of "are you in
> favor of seeing if HCFA would create a temporary 1:1 xwalk
> NDC:J-codes?"
> question proposed by Kepa were enthusiastically in favor of
> doing this.
> One thing to remember is that, even if HCFA does make a 1:1 xwalk, you
> certainly don't need to use it. If your company has the
> people power to
> figure out your J-codes xwalk that is fine. Remember, in NDC
> there are
> often multiple codes for the same drug - redundancy is not a
> big issue.
>
> Based on this response, I guess the ball falls in HCFAs
> court. Anybody
> from HCFA wish to comment?
>
> j
>